

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

DRUG ADDICTION TREATMENT EXPANSION ACT

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 45) to amend the Controlled Substance Act to lift the patient limitation on prescribing drug addiction treatments by medical practitioners in group practices, and for other purposes.

The Clerk read as follows:

S. 45

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MAINTENANCE OR DETOXIFICATION TREATMENT WITH CERTAIN NAR- COTIC DRUGS; ELIMINATION OF 30- PATIENT LIMIT FOR GROUP PRA- CTICES.

(a) IN GENERAL.—Section 303(g)(2)(B) of the Controlled Substance Act (21 U.S.C. 823(g)(2)(B)) is amended by striking clause (iv).

(b) CONFORMING AMENDMENT.—Section 303(g)(2)(B) of the Controlled Substance Act (21 U.S.C. 823(g)(2)(B)) is amended in clause (iii) by striking "In any case" and all that follows through "the total" and inserting "The total".

(c) EFFECTIVE DATE.—This section shall take effect on the date of enactment of this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Georgia (Mr. DEAL) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Georgia (Mr. DEAL).

GENERAL LEAVE

Mr. DEAL of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material in the consideration of this Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. DEAL of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the Speaker for allowing us to consider the Drug Addiction Treatment Expansion Act, S. 45.

In 2000, Congress passed the Drug Addiction Treatment Act which has resulted in improved access to drug abuse treatment. This law has allowed qualified practitioners to prescribe addiction treatment medications from their office settings so long as the number of patients to whom the practitioner provides such treatment does not exceed 30 patients.

However, the Drug Addiction Treatment Act also limited the number of patients a group practice could treat to 30 as well. This limitation has created an unnecessary barrier to access to drug addiction therapy. Under current

law, a practice of 500 doctors would still be limited to treating only 30 patients in the same way as a single physician. This policy effectively limits the ability of patients to get access to treatment for their drug addictions.

This legislation before us today would lift the 30-patient limit for group practices, but would still keep in place the 30-patient limit for individual physicians.

I thank the gentleman from Indiana (Mr. SOUDER) for his leadership on this legislation that further expands access to needed addiction therapy. The Committee on Energy and Commerce and the Committee on the Judiciary have both favorably reported companion bills to S. 45, and I urge my colleagues to support this legislation today.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2 minutes.

Drug addiction is a problem we must face both at the individual and the systemic level. We bear the cost of addiction as a society. These costs are measured in lives and unmet human potential; and, frankly, in dollars.

A recent study by the National Institutes of Health found the economic cost of drug abuse totaled some \$100 billion a year, costs borne by all members of society by increased demand on our health care system and our criminal justice system.

H.R. 869, the Drug Addiction Treatment Expansion Act, addresses an anomaly in the current law that limits access to an effective drug addiction treatment.

To ensure proper oversight of drug addiction treatment, current law limits the number of patients any one doctor can treat. However, this restriction inadvertently limits group practices to the same 30-patient limit. This legislation clarifies that each doctor in a group practice is subject to the 30-patient limit, not the group practice as a whole.

This bill will expand access to effective addiction treatment. When we come together to fight addiction, we must use every means available. This bill gives doctors an improved and important tool. H.R. 869 has the support of a range of organizations, including the American Psychological Association and the Partnership for a Drug Free America. I am pleased to support its passage.

Mr. Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I yield 5 minutes to the gentleman from Indiana (Mr. SOUDER), who is the author of the House companion legislation.

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Mr. SOUDER. I thank the gentleman from Georgia, and I appreciate his leadership in moving this through his subcommittee. We served together on the Drug Policy committee in Government Reform where he served ably as

vice chairman before moving up to this important subcommittee chairmanship over in Energy and Commerce and understands directly the need for drug treatment.

Mr. Speaker, we can work for interdiction. We can work for eradication down in Colombia and Afghanistan. We can work to try to seize it as it moves through the Caribbean and through the Pacific. We can work to try to catch it at the borders. We can try to take down the delivery people.

We will continue to do that. We will continue to work through our national ad campaign, through school programs to try to prevent drug use. But ultimately many people in America become addicted. The question is, How can we treat them? As has already been explained, this was an unintended consequence of the original act. I appreciate Senator LEVIN's help on the Senate side in moving this bill that group practices were capped at 30 patients as well.

Between 1997 and 2000, the number of treatment admissions for primary heroin abuse increased 21 percent while treatment admissions for primary abuse of narcotic painkillers increased at an unprecedented 186 percent. In view of the skyrocketing numbers of treatment admissions for primary opiate addiction in recent years, it is imperative that measures be taken at the Federal level to provide adequate treatment options. Given this epidemic of drug abuse in America, drug addiction treatment programs must effectively correspond to the widespread nature of this problem. In order to expand drug treatment programs, please support this bill, the Drug Addiction Treatment Expansion Act, which will remove the 30-patient limit currently imposed on group practices.

According to the American Medical Association, the current 30-patient cap has limited access to effective substance abuse treatment services. There is a broad consensus according to AMA in the medical community that buprenorphine is a major new tool to fight addiction and does not have a high potential for misuse or fatal overdose. Lifting the cap would enable group practices to treat more patients with this highly effective drug.

There are 49 different, well-respected drug treatment organizations that back this bill, including the American Medical Association, the National Association of State Alcohol and Drug Abuse Directors, the American Psychiatric Association, the American Psychological Association, the Association of American Medical Colleges, the Alliance of Community Health Plans, and the American Medical Group Association.

And then in addition to all these medical groups, are almost all the major anti-drug groups in America, including the Partnership for a Drug-Free America, the Community Anti-Drug Coalitions of America, Drug-Free Schools Coalition, Drug Free America

Foundation, the Save Our Society From Drugs, Drug-Free Kids, America's Challenge.

I include this list of 49 groups for the RECORD.

American Medical Association (AMA)
 National Association of State Alcohol and Drug Abuse Directors (NASADAD)
 American Psychiatric Association (APA)
 American Psychological Association (APA)
 Association of American Medical Colleges (AAMC)
 Alliance of Community Health Plans (ACHP)
 American Osteopathic Academy of Addiction Medicine (AOAAM)
 American Medical Group Association (AMGA)
 American Academy of Addiction Psychiatry (AAP)
 Partnership for a Drug-Free America
 Community Anti-Drug Coalitions of America (CADCA)
 American Society of Addiction Medicine (ASAM)
 American Association for the Treatment of Opioid Dependence (AATOD)
 Legal Action Center (LAC)
 National Alliance of Methadone Advocates (NAMA)
 National Association of Drug Court Professionals (NADCP)
 National Council on Alcoholism and Drug Dependence (NCADD)
 State Associations of Addiction Services (SAAS)
 National Association of Counties (NACO)
 Kaiser Permanente
 National Association of County and City Health Officials (NACCHO)
 National Association of County Behavioral Health Directors (NACBHD)
 The College on Problem of Drug Dependence (CPDD)
 The Friends of NIDA
 Faces & Voices of Recovery
 Association for Addiction Professionals of New York
 Drug-Free Schools Coalition
 Drug Free America Foundation, Inc. (DFAF)
 Save Our Society From Drugs (SOS)
 Drug-Free Kids: America's Challenge
 Advocates for Recovery Through Medicine (ARM)
 National Families in Action (NFIA)
 National Association of Social Workers (NASW)
 Man Alive, Inc.
 Institute on Global Drug Policy (IDGP)
 International Scientific and Medical Forum on Drug Abuse
 Californians For Drug-Free Youth (CADFY)
 National Alliance of Advocates for Buprenorphine Treatment, Inc.
 Christian Drug Education Center
 New Jersey Federation for Drug Free Communities
 Wisconsin Families in Action (WFIA)
 New York Academy of Medicine (NYAM)
 American Academy of Pediatrics (AAP)
 Association for Medical Education and Research in Substance Abuse (AMERSA)
 Physicians and Lawyers for National Drug Policy (PLNDP)
 Entertainment Industries Council, Inc. (EIC)
 The City of New York, New York
 Providence Breakthrough
 International Study Group Investigating Drugs as Reinforcers (ISGIDAR)
 Housing Works

I think that we can unanimously support this bipartisan effort to make sure that we have another tool in an ade-

quate way with group practices to make sure that we can treat the scourge of drug addiction and help many family members get back into their families, whether it be the mom, the dad, the kids; and this is the way we can in a bipartisan way and with the other body show that we really are trying to address these difficult questions of drug treatment.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. CAPUANO).

Mr. CAPUANO. Mr. Speaker, I rise to first of all thank the gentleman from Indiana (Mr. SOUDER) for being so dogged on this issue. As we have heard already, this is a relatively simple item. We have people who need treatment. I thought we were here to try to help people seek treatment and to provide it and we have an anomaly in the law that prevents them from getting the treatment that they want and that we want to provide them. This bill fixes that anomaly. It is very simple.

I will fully admit that I did not find this on my own. I found this because a doctor in my own district called me, Dr. Schmitt from Mass General Hospital, who works out of the Charlestown Community Health Center. He treats these people. He wants to be able to treat more. Unfortunately, he works in a group practice and is limited to 30. He will be able to help more people in his own community, which will help the community at large.

This bill is a modest piece of legislation. It simply allows more people to be treated. It is not a panacea, it is not going to fix our drug problem, but it is going to increase access to these treatments I believe that all Americans want us to do for their sons and daughters who have fallen victim to the terrible sins of drug abuse.

Mr. Speaker, I urge the passage of this bill. Again, to repeat, I want to thank the gentleman from Indiana for his tenacious push of this bill.

Mr. DEAL of Georgia. Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 4 minutes to the gentleman from Maryland (Mr. CUMMINGS).

Mr. CUMMINGS. I thank the gentleman for yielding time.

Mr. Speaker, I rise today in support of S. 45, which amends the Controlled Substances Act to lift the patient limitation on prescribing drug addiction treatments by medical practitioners in group practices. This bill is the companion legislation to H.R. 869, which I have cosponsored. On that subject, let me acknowledge the sponsorship of H.R. 869 by the distinguished gentleman from Indiana (Mr. SOUDER). As Chair and myself as ranking member of the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources, we have worked tirelessly on the issue and are pleased to have it considered on the floor today.

In 2000, Congress passed the Drug Addiction Treatment Act, otherwise

known as DATA, to expand treatment options for patients addicted to opiates. To address concerns about potential abuse or diversion of the treatment medications, DATA limited the prescription of this drug to 30 patients per physician. Unfortunately, DATA also contained language that imposed a 30-patient cap on group practices in addition to the limit per physician. This resulted in an unintended effect of limiting large group practices such as that of Johns Hopkins Medical Center in my district from meeting the high demand for drug treatment. However, S. 45 would eliminate this disparity by removing the 30-patient limit imposed on group practices, thereby expanding access to treatment for all patients regardless of where they receive their medical care.

S. 45 is especially important for my district which includes Baltimore City. According to the latest data available, Baltimore has the third highest rate per 100,000 people of heroin-related addictions among the 21 metropolitan areas reporting this information. Further, Baltimore's heroin use ranked at 195, which is much higher than the national rate of 37. Heroin abuse counted for the most drug treatment admissions to publicly funded facilities in the city from July 1, 2001, through June 30, 2002. In addition, mortality data indicate that there were 349 heroin/morphine-related deaths in the Baltimore metropolitan area in 2001, more than for any other illicit drug.

I must also note that heroin abuse via injection has contributed significantly to the number of HIV cases in the Baltimore area. S. 45 would greatly reduce these numbers by increasing the availability of treatment medications such as buprenorphine or "bupe" in institutions such as teaching hospitals and community health clinics. Treatment medications such as buprenorphine will allow more people to remain productive while trying to overcome their drug addiction. Experts say that buprenorphine leaves patients more clearheaded than methadone and produces less intense withdrawal symptoms. They point out that in the brain, buprenorphine behaves like heroin but works more slowly and less efficiently than other opiates. In other words, this specific treatment reduces or eliminates withdrawal symptoms without producing euphoria.

When we passed the law in 2000, our legislation limited bupe's availability because we wanted to avoid the creation of prescription-writing mills. It is important to note that this bill will not open prescription-writing mills. Rather, it would expand access so that more physicians in large group practices would be able to prescribe the drug.

I urge my colleagues to support S. 45. This is an important piece of legislation.

Mr. BROWN of Ohio. Mr. Speaker, I yield back the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I would simply urge my colleagues to support this legislation.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and pass the Senate bill, S. 45.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. DEAL of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING ACT OF 2005

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1132) to provide for the establishment of a controlled substance monitoring program in each State, as amended.

The Clerk read as follows:

H.R. 1132

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National All Schedules Prescription Electronic Reporting Act of 2005".

SEC. 2. PURPOSE.

It is the purpose of this Act to—

(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

(2) establish, based on the experiences of existing State controlled substance monitoring programs, a set of best practices to guide the establishment of new State programs and the improvement of existing programs.

SEC. 3. CONTROLLED SUBSTANCE MONITORING PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding after section 399N the following: "SEC. 399O. CONTROLLED SUBSTANCE MONITORING PROGRAM.

"(a) GRANTS.—

"(1) IN GENERAL.—Each fiscal year, the Secretary shall award a grant to each State with an application approved under this section to enable the State—

"(A) to establish and implement a State controlled substance monitoring program; or

"(B) to make improvements to an existing State controlled substance monitoring program.

"(2) DETERMINATION OF AMOUNT.—

"(A) MINIMUM AMOUNT.—In making payments under a grant under paragraph (1) for

a fiscal year, the Secretary shall allocate to each State with an application approved under this section an amount that equals 1.0 percent of the amount appropriated to carry out this section for that fiscal year.

"(B) ADDITIONAL AMOUNTS.—In making payments under a grant under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an additional amount which bears the same ratio to the amount appropriated to carry out this section for that fiscal year and remaining after amounts are made available under subparagraph (A) as the number of pharmacies of the State bears to the number of pharmacies of all States with applications approved under this section (as determined by the Secretary), except that the Secretary may adjust the amount allocated to a State under this subparagraph after taking into consideration the budget cost estimate for the State's controlled substance monitoring program.

"(3) TERM OF GRANTS.—Grants awarded under this section shall be obligated in the year in which funds are allotted.

"(b) DEVELOPMENT OF MINIMUM REQUIREMENTS.—Prior to awarding a grant under this section, and not later than 6 months after the date on which funds are first appropriated to carry out this section, after seeking consultation with States and other interested parties, the Secretary shall, after publishing in the Federal Register proposed minimum requirements and receiving public comments, establish minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).

"(c) APPLICATION APPROVAL PROCESS.—

"(1) IN GENERAL.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such assurances and information as the Secretary may reasonably require. Each such application shall include—

"(A) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(A)—

"(i) a budget cost estimate for the controlled substance monitoring program to be implemented under the grant;

"(ii) criteria for security for information handling and for the database maintained by the State under subsection (e) generally including efforts to use appropriate encryption technology or other appropriate technology to protect the security of such information;

"(iii) an agreement to adopt health information interoperability standards, including health vocabulary and messaging standards, that are consistent with any such standards generated or identified by the Secretary or his or her designee;

"(iv) criteria for meeting the uniform electronic format requirement of subsection (h);

"(v) criteria for availability of information and limitation on access to program personnel;

"(vi) criteria for access to the database, and procedures to ensure that information in the database is accurate;

"(vii) criteria for the use and disclosure of information, including a description of the certification process to be applied to requests for information under subsection (f);

"(viii) penalties for the unauthorized use and disclosure of information maintained in the State controlled substance monitoring program in violation of applicable State law or regulation;

"(ix) information on the relevant State laws, policies, and procedures, if any, regarding purging of information from the database; and

"(x) assurances of compliance with all other requirements of this section; or

"(B) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(B)—

"(i) a budget cost estimate for the controlled substance monitoring program to be improved under the grant;

"(ii) a plan for ensuring that the State controlled substance monitoring program is in compliance with the criteria and penalty requirements described in clauses (ii) through (viii) of subparagraph (A);

"(iii) a plan to enable the State controlled substance monitoring program to achieve interoperability with at least one other State controlled substance monitoring program; and

"(iv) assurances of compliance with all other requirements of this section or a statement describing why such compliance is not feasible or is contrary to the best interests of public health in such State.

"(2) STATE LEGISLATION.—As part of an application under paragraph (1), the Secretary shall require a State to demonstrate that the State has enacted legislation or regulations to permit the implementation of the State controlled substance monitoring program and the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained in such program.

"(3) INTEROPERABILITY.—If a State that submits an application under this subsection geographically borders another State that is operating a controlled substance monitoring program under subsection (a)(1) on the date of submission of such application, and such applicant State has not achieved interoperability for purposes of information sharing between its monitoring program and the monitoring program of such border State, such applicant State shall, as part of the plan under paragraph (1)(B)(iii), describe the manner in which the applicant State will achieve interoperability between the monitoring programs of such States.

"(4) APPROVAL.—If a State submits an application in accordance with this subsection, the Secretary shall approve such application.

"(5) RETURN OF FUNDS.—If the Secretary withdraws approval of a State's application under this section, or the State chooses to cease to implement or improve a controlled substance monitoring program under this section, a funding agreement for the receipt of a grant under this section is that the State will return to the Secretary an amount which bears the same ratio to the overall grant as the remaining time period for expending the grant funds bears to the overall time period for expending the grant (as specified by the Secretary at the time of the grant).

"(d) REPORTING REQUIREMENTS.—In implementing or improving a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subsection (a)(1)(B) submit to the Secretary for approval a statement of why such compliance is not feasible or is contrary to the best interests of public health in such State, with the following:

"(1) The State shall require dispensers to report to such State each dispensing in the State of a controlled substance to an ultimate user not later than 1 week after the date of such dispensing.

"(2) The State may exclude from the reporting requirement of this subsection—

"(A) the direct administration of a controlled substance to the body of an ultimate user;

"(B) the dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less; or

"(C) the administration or dispensing of a controlled substance in accordance with any